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Proceedings of the National Deaf-Blind Educational/Rehabilitation Exchange



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"The Challenge of Creating Rainbows"

Presented by Richard Kinney
President, Hadley School for the Blind,
Winnetka, Illinois

From the moment I started counting the syllables in the title of this conference, I realized that keynoting it was likely to be my greatest adventure yet in higher mathematics. Incidentally, to save you the trouble of ad hoc consultation with the nearest computer programmer, I'll specify that our conference title has 21 syllables, a fact I interpret as symbolizing the age at which education and rehabilitation traditionally meet.

One great achievement of this conference is the fact that we are meeting at all. Too often in the past, educators and rehabilitators of deaf-blind persons have cruised their separate courses like ships that pass in the silent night. I am especially pleased to find parents of deaf-blind children strongly represented at this conference. Certainly, it would seem self-evident that parents, teachers, and rehabilitators of deaf-blind persons should meet and consult with one another to exchange views, to pool knowledge, to formulate objectives, and to dream dreams.

The river of thought like a river of water grows and becomes powerful by gathering strength from many tributaries. Each of us has something to contribute to this conference, and my role as your keynoter is primarily one of stimulating your own contribution. From the outset, therefore, let me urge you to be a conference of incendiary bombs, not a conclave of fire extinguishers. Think! Brainstorm! Have the courage to envision laws that lift us up—not drag us down. Be so distinctive you come out distinguished.

In my role as President of the Hadley School for the Blind and chairman of the Committee on Services to the Deaf-Blind of the World Council for the Welfare of the Blind, I am both an educator and a rehabilitator. As such, let me present for your consideration the definition adopted in September, 1977, in New York City by delegates to the first Helen Keller World Conference on Services to Deaf-Blind Youths and Adults. The definition states that deaf-blind individuals are "persons who have substantial visual and hearing losses, such that the combination of the two causes extreme diffi-

culty in the pursuit of educational, vocational, avocational, or social goals."

The key word in the definition is "combination." The person with substantial visual loss can still hear and listen. The person with substantial hearing loss can still see and observe, but the person with substantial losses of both sight and hearing experiences a combination of sensory deprivation that may cause extreme difficulty in achieving life's most vital goals. Such an individual is by definition deaf-blind.

The foregoing definition has the merit of being functional rather than technical. Few things can be more heartbreaking than to tell a person experiencing severe sight-hearing loss that he or she is not quite blind enough or not quite deaf enough to meet some technical requirement for help. Life is more important than any technicality. Deaf-blindness in its extreme form means simply that one cannot see, one cannot hear, one must rely wholly and utterly on the sense of touch to communicate with one's fellow human beings. This is precisely what deaf-blindness means to me as an individual.

I cannot see the brightest sight and if the atomic bomb went off under my chair this afternoon, I doubt that I could hear it. Deaf-blindness need not be total to present severe and special problems that require special solutions.

If any individual has substantial visual loss and substantial hearing loss and the combination of the two is causing extreme difficulty in securing an education, in securing employment, in enjoying recreation, or in gaining social participation, then that individual is deaf-blind and needs our help.

As to the rights of the deaf-blind person, the Helen Keller World Conference on Services to Deaf-Blind Youths and Adults unanimously adopted a declaration on this very subject. The declaration is presented here with my comments following each article.

Preamble. Delegates from 30 countries around the world assembled for this first international conference on services to deaf-blind youths and adults, welcoming

the United Nations Declaration of Human Rights and the Declaration on the Rights of Disabled Persons, have agreed upon and have adopted the following Declaration specifically concerning the needs and rights of deaf-blind persons and commend it to the attention of the world community:

Article 1. Every deaf-blind person is entitled to enjoy the universal rights that are guaranteed to all people by the United Nations Declaration of Human Rights and the rights provided for all disabled persons by the Declaration on the Rights of Disabled Persons.

Article 1 simply states that deaf-blind people are human beings with the same basic rights as all other people, including all other handicapped people.

Who would deny such a statement? A noted U.S. rehabilitation expert once described deaf-blind people as "vegetables." I trust that by now the vegetables have grown and succeeded.

Article 2. Deaf-blind persons have the right to expect that their capabilities and their aspirations to lead a normal life within the community and their ability to do so shall be recognized and respected by all governments, administrators, educational and rehabilitation personnel, and the general public.

Deaf-blind persons expect the community to recognize both their desire and their capacity to live normal lives as human beings. The things that make you happy or make you sad make deaf-blind individuals happy or sad. It is as simple as that.

Article 3. Deaf-blind persons have the right to receive the best possible medical treatment and care for the restoration of sight and hearing and the services required to utilize remaining sight and hearing, including the provision of the most effective optical and hearing aids, speech training, when appropriate, and other forms of rehabilitation intended to secure maximum independence.

Article 3 refers to our earlier point that deaf-blindness need not be total; in fact, every bit of residual sight and hearing should be utilized and enhanced both through medical care and through modern technology. Since communication is a two-way exchange, any training that advances a deaf-blind person's ability to speak will be tremendously helpful. Please note that the goal sought is to increase the independence of the deaf-blind person.

Article 4. Deaf-blind persons have the right to economic security to ensure a satisfactory standard of living and the right to secure work commensurate with their capabilities and abilities or to engage in other meaningful tasks, for which the requisite education and training shall be provided.

Article 4 could be summarized as the right to be useful, to work, to contribute, to feel one is giving to others as well as receiving from others.

I have noted that every time a deaf-blind man or woman gains a paying job, he or she gains new respect. Money is a great equalizer. The best passport to independence is an adequately filled pocketbook.

Article 5. Deaf-blind persons shall have the right to lead an independent life as an integrated member of the family and community, including the right to live on their own or to marry and raise a family. Where a deaf-blind person lives within a family, greatest possible support shall be provided to the whole family unit by the appropriate authorities. If institutional care is advisable, it shall be provided in a surrounding and under such conditions that it resembles normal life as closely as possible.

Please note that Article 5 not only asserts that deaf-blind persons have the right to be part of the family environment but also the right to live alone or to be head of a family. Individual desires and circumstances will vary, but the right is inherent. Some deaf-blind persons live happily with their parents. Others have married and are themselves successful parents. Still other deaf-blind persons live independently in their own apartments or prefer the security and comfort of a well-run institutional home. I lived alone in my own bachelor apartment for five years as a young man, and later married a blind woman with normal hearing. I am now the proud father of a fifteen-year-old son who specializes in golf, baseball, and all forms of pictorial art. The deaf-blind person's right to a family life is as old as Adam and Eve.

Article 6. Deaf-blind persons shall have the right, and at no cost, to the services of an interpreter with whom they can communicate effectively to maintain contact with others and with the environment.

Article 6 emphasizes the vital importance to a deaf-blind person of interpreter services as a communication link with the community. The words "free of cost" have caused some controversy, but it was the thought of the conference that many deaf-blind persons, especially children or the elderly, simply will not have the personal funds with which to employ interpreters. Whether the answer lies in volunteer interpreters, interpreters supplied by private social agencies, government-provided interpreters, or a combination of all three, will probably depend on the philosophy and culture of each society, but the right to communicate is perhaps the greatest single right for which a deaf-blind person longs. The

human mind will break through any barrier to reach other human minds.

Article 7. Deaf-blind persons shall have the right to current news, information, reading matter, and educational material in a medium and form which they can assimilate. Technical devices that could serve to this end shall be provided, and research in this area shall be encouraged.

Article 7 extends and reemphasizes the right of the deaf-blind person to information and knowledge about the world in which he or she lives. After all, the basic senses are merely channels through which the mind observes and communicates with the community and with the environment. What really matters is the mind behind the senses: to know is more important than to see; to understand is more important than to hear.

Article 8. Deaf-blind persons shall have the right to engage in leisure-time recreational activities, which shall be provided for their benefit, and the right and opportunity to organize their own clubs or associations for self-improvement and social betterment.

Article 8 draws attention to the fact that life is not all work and earnest endeavor but should also contain a vital element of recreation and enjoyment. Because they have much in common, many deaf-blind individuals take pleasure in sharing activities with other deaf-blind persons. Mutual life enhancement, after all, is one of the great foundation stones of civilization.

Article 9. Deaf-blind persons shall have the right to be consulted on all matters of direct concern to them and to legal advice and protection against improper abridgment of their rights due to their disabilities.

Again and again, the deaf-blind individual has cried out for a larger part in shaping his or her own destiny. The right to make one's own decisions is the basis of freedom. Like all other people, the deaf-blind person needs options from which to

choose—alternatives from which to select. Only by exercising his or her own judgment can a deaf-blind person function as a fully equal citizen in the community. The enumerated rights of the deaf-blind person will not be achieved in a day or in a year or in any specific time.

Some may call the foregoing articles idealistic dreams, yet the world is built on dreams—dreams that have come true or are in the process of coming true. Such dreams imply responsibility. The deaf-blind person who demands knowledge and training as a right also accepts the responsibility to develop his or her own potential for the benefit of the community. The deaf-blind person who insists on respect and independence as a right also accepts responsibility for his or her own actions and respects the rights of others.

Handicapped or unhandicapped, we are all human beings living on one planet and sharing one destiny. What does life require of us but to do our best for ourselves and for each other.

I want to give you two final guidelines from my own experience. To parents and teachers: First give love; then give knowledge. Remember that, until children can dream for themselves, we must dream for them. Every deaf-blind child who achieves his or her own highest potential, be that potential great or small, is a successfully educated child. To rehabilitators: In the world of work, let us plan from the aptitude out—discover the talent, train the talent, and then place the talent. The handicapped individual is by very definition more individual—less "run of the mill"—than his or her unhandicapped peers. Find the strong point, and build on it like a rock.

Every storm should have a rainbow. It is our privilege, indeed it is our challenge, to create rainbows, or still better, to help deaf-blind persons create their own rainbows in a world that deserves to be lived in.

Assessment of Deaf-Blind Children in Retrospect

Presented by
Bernita Sims-Tucker, Coordinator,
Moderate to Profoundly Handicapped Program
Coppin State College, Baltimore, Maryland

In the area of educating visually, auditorally, or motorically impaired children and adolescents, we have come a long way. Not too long ago educators of these multihandicapped (deaf-blind) children were not even considering formal or educational assessment of their students. It was not because they were not believers of evaluation; it was because appropriate tools for assessment were not available.

The history of education for deaf-blind children shows that educators were trying to develop curricula without any base from which to build. Educational plans were often developed from a hit-and-miss technique. One would hear a teacher say, "I'll try this today; if it doesn't work, I'll try something different tomorrow." What is all too sad is that some of us are still at that stage. Some educators have found techniques and methods that seem to be magic for their deaf-blind children. They have wrapped this information in little neat packages and have called them deaf-blind curricula, plans for deaf-blind children, or management guidelines. Whatever the terminology used, it all boils down to "cookbooks." These can be very helpful to beginning teachers; however, what has been happening is that some educators try to plug their students into those programs. Needless to say these attempts often end in frustration for both teacher and learner.

Things began to change when educators became more sophisticated in their approach to developing educational programming for the students; however, much is yet to be done in the area of assessment and curriculum development for the deaf-blind.

Once educators observed that trying to fit a deaf-blind child to a curriculum was not a very successful technique, they turned their efforts toward evaluation. Naturally, assistance was sought from ancillary staff such as psychologists, who were asked to evaluate the visually and auditorally impaired children. Most psychologists were at first unable to assist the teachers in any kind of formal

assessment of their students. Most of the children they were asked to evaluate could not even sit at a table for more than a few minutes without engaging in self-stimulatory behavior. The children often would bite, kick, or scratch the examiner. Psychological testing protocol dictated that testing should be done in the psychologist's office, with unfamiliar toys and without the presence of the classroom teacher or any other familiar person. When the brave psychologist who dared to enter into a testing situation with a deaf-blind child returned him or her to the classroom, both the examiner and child were totally frustrated.

The psychologist's report would state, "untestable . . . deaf-blind program appropriate placement." Other psychologists tried to use standard tests on these deaf-blind students. Because deaf-blind children come in all sizes, shapes, colors, and intellectual ability, it was possible to use some of the existing protocols on this population. For some students the psychologists were able to obtain reliable data and tabulate IQ scores, but the teacher was again faced with the question "Now what?" The IQ score showed that the child had a learning disability. The teacher probably already had guessed this. The teacher was left to his or her own devices. Finally, more educational assessment tools became available. These tools made it possible for classroom teachers to conduct their own assessments for planning purposes. The development of these tools opened a totally new area for the deaf-blind child and his or her teacher.

The initial assessment tools were not developed to give the educator an IQ or developmental age; rather, they were designed to pinpoint for the teacher the child's sequential level. These tools usually were checklists of gross- and fine-motor skills, social abilities, self-care levels, and sometimes auditory and visual sequential steps. Each area was broken down into minute steps by the use of task analyses. These scales were not all developmental scales, and most did not give the educator any kind of developmental functioning level.

The field of education for the deaf-blind again began to become more sophisticated. More training programs for teachers of the deaf-blind were established. Better-prepared and more enthusiastic teachers began working with the deaf-blind. These educators wanted to know more about their students than where each child was placed on a sequential scale. The teachers knew that most of their students had splinter skills. Some teachers still found it difficult to develop programs for their deaf-blind students. The teachers began to ask questions of themselves: "Why are we trying to assess these students? Why are we still trying to plug them into scales that are not developed for children with impairment in two or more sensory modalities? What do we need to know in order to appropriately plan for the deaf-blind child in the classroom and in the home? Can any test instrument give us a prediction for future performance? Can we use a tool to indicate developmental change?"

Because I am an educator, I tend to look at tools that will help me to evaluate a student's present educational functioning level, developmental level (gross- and fine-motor skills, visual ability, and the like), socialization level, and prevocational skills level. It has been my experience as an educational diagnostician that no one scale can tell us everything we need to know to set up a program for a deaf-blind child. In my present professional position, I am called upon to evaluate deaf-blind children (birth to twelve years of age) and young adults (twelve to twenty-one years of age). I have found that, even when working with deaf-blind children from birth to three years of age, several scales and checklists must be used to develop a diagnostic/therapeutic program for the child and his or her parents.

Recently, new scales that claim to be designed for assessing the deaf-blind multihandicapped child have become available. However, I have chosen scales with which I feel most comfortable and with which I can obtain the information I need to know about a particular child. The key point here is that now educators can choose from among several scales.

One tool that is often used to evaluate children at the David T. Siegel Institute is the *Gesell Developmental Scale*, which measures four fields of behavior. These are (1) motor behavior (gross and fine); (2) adaptive behavior; (3) language development; and (4) personal-social behavior. Such developmental schedules indicate the exact ages of development. They are very helpful because they

not only do get an average age, but a developmental age for each field of behavior. This type of assessment of developmental behavior is extremely helpful with children who are orthopedically handicapped, severely profoundly handicapped, and severely neurologically impaired.

Even though the *Vineland Social Maturity Scale* has its shortcomings when used with the deaf-blind population, it too can be helpful in assessing the deaf-blind student. The *Vineland Scale* is not an intelligence test. It gives the examiner a good sampling of a child's growth in areas that include achievement, personality, and emotionality. The scale indicates a social age, not an IQ score. The *Vineland Scale* gives the teacher specific age levels for each of eight performance items. It covers such areas as general self-help skills, self-direction skills, occupational skills, and socialization skills.

The *Callier-Azusa Scale* was specifically developed for the deaf-blind student. It can be administered by the classroom teacher or other individual who has close contact with the child. Previously, the psychologist would remove the child from the environment with which he or she was most familiar. Results, needless to say, were not favorable. Consequently, this scale was developed for the classroom teacher, who would be more familiar with the child. The collected data thus had more validity. The *Callier-Azusa Scale* was a pioneer scale developed especially for the deaf-blind child. It has gone through several revisions since its conception. This sequential scale is developmental in its approach. The scale covers five major areas, each of which has subscales. The major areas are: motor development, perceptual development, daily living skills, language development, and socialization.

Another checklist which has been especially designed for the deaf-blind student is *A Manual for Assessment of a Deaf-Blind Multiply Handicapped Child*, which was published by the Midwest Regional Center for Services to Deaf-Blind Children. It, like the *Callier-Azusa Scale*, is in a checklist format and is designed to be administered by the classroom teacher or others who work closely with the child. Both scales avoid the foreign atmosphere of having a stranger evaluate a child in a strange room with strange materials. That in itself gives both scales a plus and minus value. Too often our deaf-blind students are involved with their own environment and materials. Concepts are not learned, but instead what takes place is learning of specific tasks. When these protocols are used, one must be careful to test any particular item with

different materials and have several persons administer the scale.

The problem of program planning does not end with discovering at what developmental level a child is functioning. To develop a program for each child, the teacher can use curriculum guides that describe what to do and how to do it. Curricula that include assessment tools also are available. These scales have combined developmental analysis or assessment with suggestions for training activities. A very good example of such a scale is the *Koontz Child Developmental Program*, which was one of the first standardized tests that used multihandicapped children to establish its norms. The multihandicapped test groups included some children with auditory and visual deficits. Besides helping the educator to determine her or his students' functioning levels, the *Koontz Program* also describes some carefully planned training activities. An extra benefit of this program is that it also indicates which task would not be appropriate for auditorially or visually impaired students. Another advantage of the *Koontz Program* is that it gives developmental age levels for expressive and receptive language up to forty-eight months of age.

The *Developmental Activities Screening Inventory (DASI)* is one of the latest scales developed specifically for the deaf-blind population. This scale was written by Rebecca Dubose of George Peabody College in Tennessee. Dr. Dubose is still in the process of field-testing this instrument. The major shortcoming for this scale is that it does not meet the needs of the lower functioning deaf-blind child. It begins its activities at the six-month level. More deaf-blind students today are in the category of severely and profoundly handicapped. These children, who are six, seven, and eight years of age chronologically, often have not yet reached the developmental age of six months. However, it is my contention that no one scale can be used with all of the deaf-blind population. Because assessment is still in its infancy, more and more resources have to be developed.

Although many advances have been made in the area of assessment for deaf-blind children, much still must be done. Educators are demanding more reliability and are being held accountable for educating this severely and profoundly handicapped population. Publishers of psychological assessment scales are trying to maintain a standard that would meet the needs of these educators and their students.

Listings of available scales may help teachers decide which scales are appropriate for their students. One such listing is published by the Southwestern Region Deaf-Blind Center. The center's staff members and others developed an assessment scale comparison instrument to provide educators with a resource for selection of assessment tools. It is an excellent composite of available scales that can be used with some of the deaf-blind population. Each area of the country has scales or checklists that have been developed in that particular region to meet the needs of the local deaf-blind population. The scales that I have described seem to be the most popular and most widely used.

Some other scales that various professionals have found helpful in evaluating deaf-blind children and young adults are the following:

1. Self-Care Tools

Denver Developmental Screening Test

Maxfield-Buckholtz

Vineland Social Maturity Scale

A Manual for Assessment of a Deaf-Blind Multiply Handicapped Child (Midwest Regional Center)

2. Sensorimotor Integration Scales

Merrill-Palmer

Jean Ayres Sensorimotor Integration

Natalie Barraga Visual Efficiency Scale
(adapted for deaf-blind children by Bernita Sims-Tucker)

Frostig Move, Learn, and Grow

3. Communication Tools

Communicative Evaluation Chart

Nelson-Denny Test

Laura Lee Developmental Sentence Scoring

Daniel Boone Infant Speech and Language Development

Sequenced Inventory of Communication
(normal development)

Receptive-Expressive Emergent Language Scale (REEL)

4. Motor, Self-Care, Social and Language Scales

Gesell Developmental Scale

Koontz Child Developmental Program

Callier-Azusa Scale

Portage Project Checklist

Preschool Attainment Record

Behavioral Characteristics Progression

Peabody Picture Vocabulary Tests

Developmental Profile Manual (Alpern and Boll)

Developmental Activities Screening Inventory

5. Intelligence Tests

Lieter International Performance Scale
Wechsler Intelligence Scale for Children
Cattell Infant Intelligence Scale
Bayley Scales of Infant Development

Other tools for assessing deaf-blind individuals are still being developed. The Consortium on Adaptive Performance Evaluation is in the process

of developing an instrument to evaluate the performance of severely and profoundly handicapped individuals who are functioning at approximately two years of age developmentally.

Much has been done to find appropriate assessment tools for use with the deaf-blind student; however, the schools are in the beginning stages of educating and evaluating the deaf-blind. Much has yet to be done.

Professional Burn-Out

Presented by LeRoy Spaniol, President; and Jennifer J. Caputo,
Director of Family Services and Programs for Special Needs Populations
Human Services Associates, Lexington, Mass.

Burn-out has become an increasingly important issue in the helping professions. We are beginning to realize that it is important to take care of ourselves while we are taking care of others. If we do not take care of ourselves, we will have much less energy for giving, caring, feeling, problem solving, creating, sharing with co-workers, loving, and enjoying. If we do not take good care of ourselves, our students/clients/patients will get less from us and may actually be harmed by us. We may become more critical of others; we may see less hope for those we are helping; we may show less love and concern; and we may even physically harm others because of our own frustration or anger. Burn-out plays a major role in the poor quality of services provided to individuals in need (Maslach, 1976).

Burn-out can be defined as "wearing yourself out doing what you have to do," "the inability to cope adequately with the stresses of our work or personal lives," "what can happen to professionals who have to work continuously with people who have serious personal problems or disabilities," or "what can happen to professionals who work in an environment which does not actively encourage participative problem solving." Thus, burn-out can result from personal as well as organizational factors.

Why is burn-out important? In the first place, it is personally and physically harmful to ourselves. For instance, the chances for an accident increase with burn-out. Burn-out is also potentially harmful to others in our personal or work environment. We may become more critical of those around us. We may see less hope for those we are helping. We may actually physically harm others.

Burn-out reduces the amount of personal energy available to constructive problem solving, creative and innovative work, excitement, caring, loving, playing, and enjoying. We each have a fixed amount of energy. If our energy is being used up in burn-out, we are cheating ourselves.

Burn-out seems to have three levels or degrees. They are as follows:

First degree. The burn-out at this level is mild. The symptoms are only occasional and they are short-lived.

Second degree. The burn-out at this level is moderate. The person experiences regular bouts that last longer and are difficult to escape.

Third degree. This level often involves tissue damage; i.e., ulcers, migraine headaches, and the like. Psychological and spiritual questioning may occur. The person begins to question the value of his or her work. He or she may question the meaning of his or her own life. The symptoms may be frequent, continuous, and difficult to eliminate.

Sources of Burn-Out

One of the major sources of burn-out is in the professional preparation of counselors, teachers, social workers, and other professionals. Professors, for example, are frequently poor models. Many do not actively practice what they preach. They are not actively counseling, teaching, seeing clients, or providing therapy. Their teaching becomes theoretical, cognitive, and distant. Also, because of their lack of "doing," they are not able to draw on their own experience to enliven the discussion.

Teachers frequently do not take good care of themselves. If they are burning themselves out, they are more likely to burn their students out. Burned-out teachers demonstrate a style of behavior that students associate with success but which, in reality, is self-destructive.

Students are not taught to deal with their own strong feelings. You cannot adequately help others to deal with their strong feelings unless you have worked through and been able to deal with your own strong feelings. Strong student feelings are frequently "discounted" or diverted because professors do not know how to handle them. It is as if "owning" feelings is for clients, not for students or professors (Warnath and Shelton, 1976).

Students are not helped to develop a strong professional identity. They are not "participative problem solvers" in relation to their graduate training programs. They are passive recipients who are expected to take what is given without complaint. They carry this passive attitude to their jobs. It is characterized by a "tell me what I should do" attitude rather than a "this is what I should be doing as a professional" attitude. A strong professional identity is developed through (1) open,

honest, and direct communication between professors and students; (2) participative problem solving; (3) fostering of a sense of personal responsibility for the kind of professional one wants to be; (4) sharing of feelings about current experiences in the program; and (5) having professors who are actively and competently practicing what they preach.

Students need to be encouraged to be their own advocates now. Advocacy begins at home and in the present. Teachers cannot expect their students to be docile and passive now and strong personal/client advocates later. Neither can teachers expect to be strong advocates for themselves if they are unconcerned about academic decisions and processes which affect their current professional lives. When you are a good advocate for yourself, you are in a much better position to be a good advocate for others.

Graduate training is short on skill-based programs designed to meet the skills deficits found in clients. Providing knowledge is not enough. Professionals are not adequately prepared to meet the skill demands of their work. We are trained to see disability as a problem rather than as a skills deficit. Someone who is disabled either is unable to do something or has not yet learned how to do it. The solution is to provide people with the skills to do what they need to do in order to get what they need or what they want. Professionals also need skills in teaching skills to others. The attitude that someone who is disabled has a "problem" is carried over to our professional lives. When we cannot do something, we feel we have a problem. When we cannot *do* something, we have a skills deficit. Getting the skills we need in order to deal effectively with our professional demands is a way of curing or preventing burn-out. Graduate training must provide professionals with the skills that students/clients/patients need and with the ability to teach skills to others. Furthermore, graduate training should provide practice in these skills under competent and caring supervision.

The World of Work

The world of work is another source of burn-out. Supervisors in the human services are frequently professionals who have previously burned out. In addition, supervisors are rarely adequately trained for their positions. They may tend to focus in on administrative detail or treat their staff like clients or patients. Supervisors have unique skill needs. If these skills are not acquired, the counselor or teacher, for example, may not have access

to the professional feedback he or she needs to increase his or her own skills repertoire.

Human service professions are noted for their lack of career ladders. Professionals frequently find themselves locked into a limited range of income potential. To increase their income, they may need to leave their job category and move into supervision or administration. This may not have been their decision if there had been greater economic options available to them.

Severe organizational constraints frequently are placed on professional duties. Professionals feel they have few options and are not prepared by their training to make demands on the organization. They feel powerless and helpless in the face of bureaucratic demands and inertia. So they wait, hoping that things will improve; and they get angry at the system for not taking better care of them. They are not trained to take care of themselves when the organization is not likely to change.

The camaraderie and peer support systems that exist in graduate school are often lost when one leaves the educational system. We are supposed to be professionals now and know how to handle our own lives and effectively help clients. The strong personal feelings about our work lives are often unexpressed and unshared with fellow professionals. Because strong personal feelings are not shared, we fail to develop the necessary peer support system. We fail to express these personal feelings of inadequacy, fright, anxiety, and frustration to our supervisor. The result is a feeling of being alone, isolated, and alienated when we are faced with a problem.

The professional does not have unlimited time to work with people. The counseling models that are popular in graduate education, for example, are useful in private practice where the professional is in control of the situation but they do not readily fit the real life situations of most professional jobs (Warnath and Shelton, 1976). In many agencies client contact is limited. Brief counseling sessions are the rule rather than the exception. Counselors feel they have limited impact on clients with whom they work. The production demands frequently lead to high paperwork demands. Counselors find themselves spending an increasing amount of their time on administrative tasks.

Because of the heavy knowledge orientation of many graduate training programs, professionals are often unprepared to deal with the professional demands of their jobs. The real world has few textbook clients or textbook solutions (Warnath and Shelton, 1976). Professionals do not have the

flexibility in applying a range of skills to a range of client needs. And the client/student/patient needs they experience in their jobs may not be those they are ordinarily exposed to in their graduate training.

Risk taking is not rewarded. When professionals do well on the job, it frequently goes unnoticed. When they make a mistake, it is noticed and often punished. Professionals feel "What's the use?" They begin to do only what is necessary to get by. Innovative and creative work requires risk taking, but organizational designs do not support it. Feedback is limited. Members of the staff do not know how they are doing. Feedback is a relatively simple, yet important, external reward. When feedback is available, it tends to be negative; but even negative feedback is better than none. Feedback is recognition, and recognition is a powerful motivator.

The tasks of professionals are highly susceptible to political influence. Whom you serve, when you serve them, and how you serve them are often not under professional control. Professionals are not prepared to deal with the political nature of their jobs. They are not trained to be political, to "operate" politically, to manipulate in their own interest or that of their clients. Furthermore, the real power and status are seen to reside in administrative roles, and these are eagerly sought after (Warnath and Shelton, 1976).

Signs and Symptoms of Burn-Out

For the purpose of this presentation, we would like to focus on several personal signs and symptoms of burn-out. Fatigue is a common sign. This may be experienced as exhaustion, sleeping more than usual, increased sick leave, absenteeism, or lack of energy on the job. Worry is a sign often mentioned by counselors. They may experience themselves taking their clients home with them—in their thoughts. Often, depression and an inability to make decisions accompany the worry. Many people experience physical symptoms such as ulcers, migraines, backaches, tension, or stress. Anger and resentment are also common signs of burn-out. When we are distracted by our symptoms, we pay less attention to our surroundings and are more likely to bump into doors, furniture, or drive carelessly. Professionals begin to ignore their own wants and needs. They do not take good care of themselves in ways that are personally nurturing. Helping is often a nonreciprocal process, and we are not taught to ask for nurturing from the people we are helping.

What to Do About Burn-Out

You should be aware of what you are doing to yourself. Awareness by itself can frequently lead to change. Awareness can also be scary. Sharing your awareness with another person can help to reduce the fright. Awareness can also help you to identify early signs and symptoms as "cues" for potential problems. Be aware of and in charge of your own symptoms.

Find someone with whom you can check out your personal concerns about your work. Make it a deliberate choice, and ask the person you choose to be available periodically to discuss personal issues and personal successes. Professionals tend to keep strong feelings to themselves. They feel their personal reactions are unique and possibly bad. Furthermore, they are often not trained to deal with their own strong feelings nor those of their clients. Putting a lid on natural emotional and physiological reactions is not healthy. The isolation of work can be devastating.

Make personal contacts. Think of four people you can contact either by phone or in person each day. Mark their names down. Make a contract with yourself to get in touch with each of them for one or two minutes each day. Share a feeling or a thought with them—and keep it brief. Making personal contact is a way of stroking yourself and others; it reduces the likelihood that you will burn yourself out.

Give yourself plenty of permission to take good care of yourself. Give yourself some personal time and space. What have you done for yourself lately? Learning how to give and take strokes is another way of taking good care of yourself.

Practice helping under good supervision. If you are experiencing burn-out helping others, practice helping appropriately under good supervision. If what you need is not available from your own supervisor, get it someplace else. Purchase it in private practice, if necessary, or from another supervisor whom you respect.

Develop a work plan. Human service workers often get caught up in crisis management. They feel overburdened by the amount of work that needs to be done. Be aware of your own physical and psychological limitations. How do you currently plan and organize your time in a normal week? What times of the day do you feel most comfortable doing what kinds of tasks? How can you build in functions that are professionally satisfying to you? Your work plan should include what needs to be done plus what you enjoy doing. Share this with your supervisors.

Plan to work with someone you enjoy being with. This will decrease the likelihood that your personal resources will be depleted. You will also be more likely to get positive strokes and feedback. Also, you will have someone with whom to solve problems. In addition, plan to be with others socially on a regular basis.

Learn to relax. Systematic relaxation can be very "energizing." It has many of the effects of the more formal approaches to meditation.

Practice regular exercise. You become less fatigued by your work when you are exercising regularly. Jogging, dancing, playing tennis, or whatever is enjoyable for you can help you to prevent burn-out.

Burn-out is not inevitable. You can learn to be aware of your own burn-out signs and symptoms. Furthermore, you can learn to be in charge of your own solutions by giving yourself permission to take better care of yourself on and off the job.

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What Is Prevocational Training?

Presented by Theodore Lockett,
Midwest Regional Center for
Services to Deaf-Blind Children

Some educators define prevocational training as everything that is taught the child. All skills, such as dressing, feeding, and toileting, have an impact on the child's ability to function in any vocational setting. Others may define prevocational training as only that training that allows the child to perform in a specific vocational area. Needless to say, problems exist with both of these definitions primarily because they miss the intent of the current prevocational movement. The intent now is to provide realistic planning and relevant programming for the child's placement after his or her educational experience.

The regional concept for educating deaf-blind children was a result of the rubella epidemic of the early 1960s. The rubella segment of the deaf-blind population is getting older and is starting to challenge the school system in many new areas: sex education, recreation and leisure-time activities, alternative living, and of course, prevocational programming, which contains all of the components just listed and more.

The schools today can provide the deaf-blind student with a wide variety of skills, if the teachers have the time to do so. This brings us to the reality of mandatory education laws. These laws may differ from state to state, but there is one awesome similarity—a limited amount of program time for each student. The schools will not be able to teach each child every skill he or she may need to reach his or her optimum level of functioning, at least not within the educational program. Because of this, the schools must ensure that each of the students will have the skills to advance to the next echelon of service, which for many will be vocational rehabilitation services. For those students who will enter other service delivery systems, the process should and must be the same with lines of communication established to identify skills that are pertinent to the specific environment that has been identified for the child. In this way each child has the opportunity to be assimilated into an environment where he or she can continue to learn and grow.

Who can benefit from prevocational programming? If prevocational programming is viewed as realistic planning and relevant programming, the deaf-blind students will be able to benefit from it. But the schools must project the environment that will best meet each child's future needs. Educators must not let their preconceived expectations and perceptions interfere. Ingenuity has brought the state of the art in deaf-blind education to the point where vocational rehabilitation services are applicable for many deaf-blind individuals. Ten years ago this would not have been the case. As methodology continues to improve and increase in power, the schools will be able to consider larger portions of the deaf-blind population for prevocational programming and for realistic and relevant rehabilitation services.

Teachers and administrators must do more, however, than just gain an understanding of various skill areas and their importance as they relate to different environmental alternatives for the deaf-blind child. The deaf-blind constitute a low-incident population group. To ensure that each student has the opportunity to continue to learn and grow after his or her educational experience, the schools must maximize the number of deaf-blind students. If the school generates only one or two formal referrals to vocational rehabilitation services a year, the rehabilitation agency will not be able to offer programs that are meaningful to the deaf-blind. The best way to maximize the numbers is to work with vocational rehabilitators to systematically identify deaf-blind students and establish formal lines of communication between teachers and rehabilitators.

Many of the children will not be able to fit into the vocational rehabilitation process, the sheltered shop environment, or the alternative living environment. The challenge then becomes to modify the environment to accommodate the special needs the child still may have after his or her educational experience. Vocational rehabilitators can provide consultation and assistance in the area of environmental modification; however, the only way this

can be achieved is through communication. This communication will allow teachers and parents to tap the body of knowledge vocational rehabilitators have to offer and, at the same time, to share the wealth of expertise teachers and parents have accrued while working intensely with the deaf-blind for a decade. The programming thus will be realistic and relevant for each child.

As more of the rubella deaf-blind individuals mature and chronologically graduate from Title VI-C programs, the accountability for what has been done for the deaf-blind since the inception of the regional centers is going to become more evident, and rightfully so. The schools have met the challenge of educating the deaf-blind admirably, but teachers and parents must take the final step in this long educational journey and look beyond the educational experience to ensure that each child receives a program that will reflect the needs of his or her future placement, so that he or she may move to the next echelon of service.

I do not want to give the impression that the only changes that need to occur in the area of prevocational and vocational training are in the

educational sector. That is not the case at all. Skills must be upgraded in the area of life preparation for the students. However, vocational rehabilitators should reevaluate the programs and service delivery systems that they now have to offer and determine whether the programs and services meet the needs of the severely and profoundly handicapped population of which deaf-blind individuals are a part.

The body of knowledge about deaf-blind and other low-incidence population groups must be expanded so that programs can be modified or developed to meet the needs of the severely involved individual who has a potential to be productive but does not fit into the rehabilitation mold. Through combined effort we can create a realistic and relevant continuum of service that will allow each deaf-blind youth and adult the opportunity to aspire to his or her optimum level of functioning.

Prevocational training for the deaf-blind should be based on realistic programming that will enhance the student's ability to assimilate into the environment that has been identified for him or her after his or her educational experience.

Prevocational Programming for the Low Functioning Deaf-Blind Child

Presented by Gretchen Stone, Prevocational Coordinator
Texas School for the Blind

Many prerequisite work skills are learned at the sensorimotor level. Prevocational programming for deaf-blind children at this level is justified for three reasons:

1. Older children, who have developed cognitive functioning at Piaget's preoperational and concrete levels, still often demonstrate gaps in their acquisition of prerequisite work skills. For example, a child may be able to duplicate a complicated wiring pattern from one board to another but may be unable to wrap the wire around a terminal. He or she may be able to package two of six different objects into a plastic bag but may be unable to secure the twister. Programming at the sensorimotor level helps ensure less splintered abilities.
2. A second reason for prevocational programming at the sensorimotor level is that, based on present rates of learning, many deaf-blind individuals may never progress beyond the sensorimotor stage. This intensifies the need for very practical, future-oriented educational programs. The placement of these children within the existing workshop system seems unrealistic. However, many of these children, when they have been given early, long-term prevocational programming, demonstrate and continue to learn skills that would enable them to participate in a work activity center or other community-based day program. It can mean the difference between custodial care in which many skills may be lost and the opportunity for placement in a productive setting that would, at the very least, help maintain the skills they learned during the school years.
3. The effects of the very intention of teaching prevocational skills to low functioning children can sometimes be justification enough. Teachers can view a child's abilities from a prevocational perspective. Sorting and matching skills are used every day in workshop activities. The spatial concepts used in work-

ing puzzles can be used in packaging. Activities such as stacking rings, turning windup toys, and unscrewing jar lids involve prerequisite assembly skills. Self-help skills are essential for those who live in group homes. Teachers and parents begin to view the child's abilities in terms of practical application. Positive expectations may carry over to the classroom.

A strong positive correlation between classroom performance and work task performance may not always exist. Some children who have more highly developed cognitive skills do not consistently maintain the quality and quantity standards that lower functioning children do. In many work settings understanding and knowledge are not as important as performance. Workshop skills are often task-analyzed so that judgment is not necessary.

The difference between children at the sensorimotor level and children at the preoperational level may be more a matter of number of prompts and rate of new learning, than error or work speed.

Staff and Time Requirements

A one-to-one student-to-staff ratio is necessary to keep the student on the task and to point out errors immediately. Teachers are the immediate and logical choice for teaching prerequisite work skills to low functioning children. Teachers know their children and know how to stimulate use of the auditory, visual, and tactile senses. They also know effective behavior programs, and they are familiar with the child's attention span. It is helpful to have a prevocational consultant or coordinator who is familiar with workshop tasks and skills. Such support personnel can give objective information about the child, provide some direct services, and initiate contact with rehabilitation personnel.

Programming is frequently most effective when it occurs on a daily basis for a short period of time. Initially, a child's work tolerance may be as short

as 1 minute. Later, a 20-minute session may be tolerated. Work sessions should occur at a regular time in a specially designated place where no other type of activity occurs. This encourages expectation of good work behavior.

Prevocational skills should be defined and "isolated" to give a work potential perspective toward a child; however, prevocational programming should be an integrated part of the educational plan.

Appropriate Goals and Objectives

Some deaf-blind children have limited experience in interacting with their environment for exploratory purposes. As a result, efficient grasp and release patterns develop more slowly, and concepts such as objects in space are distorted. A beginning goal for the child may be to learn to manipulate objects. Six long-term goals and their sample objectives are presented here.

1. To internalize the work routine, the student may use the following sample objectives:
 - a. Travel to work training area.
 - b. Check in and out of work.
 - c. Find shelf, and store work materials.
 - d. Find work station.
 - e. When one task is completed, stand and go get the next task until all have been completed.
 - f. Demonstrate some comprehension that a particular task has been completed. (Once the routine is learned, intermittent and changing physical obstacles are added to see if the child is still able to maintain the routine. Physical, gestural, and verbal prompts are used to aid the child in learning the initial routine.)
2. To improve hand strength and coordination (motor accuracy), the student may use the following sample objectives:
 - a. Demonstrate whole hand grasp and release patterns.
 - b. Use prehension patterns.
 - c. Show motor planning.
 - d. Place parts at different spatial angles.
 - e. Use eye-hand coordination.
 - f. Consistently start and finish a task with the same hand.
 - g. Stabilize work with one hand while working with the other.
 - h. Carry a tray of materials (thumb isolated).
 - i. Pick up one object at a time (not a whole handful).
 - j. Increase hand strength (open tight lids, carry heavy things, and hammer or pound with some force).
 - k. Improve bilateral functioning in parallel, alternating, and opposing movements.
3. To perform a variety of tasks commonly associated with sheltered workshop activity (including several from each of the following categories: sorting, assembling, packaging, and counting), the student may use the following sample objectives:
 - a. Fit one object into its exactly fitting space.
 - b. Fit multiple objects into one larger exactly fitting space.
 - c. Match colors, sizes, shapes, and textures.
 - d. Recognize top from bottom, and place parts all on one side.
 - e. Twist around a stationary point.
 - f. Open and close containers.
 - g. Demonstrate object permanency as it relates to packaging activities.
 - h. Consistently turn in one direction.
 - i. Fit two objects together.
4. To follow directions and communicate needs in a workshop setting, the student may use the following sample objectives:
 - a. Communicate toileting needs.
 - b. Follow signs or natural gestures.
 - c. Follow pointing gestures.
5. To sit at a work station and work independently, the student may use the following sample objectives:
 - a. Stay on task.
 - b. Control self-stimulatory behaviors so they do not significantly interfere with work speed and quality.
 - c. Keep frustration and anger under control.
6. To follow sequences in a work activity, the student may use the following sample objectives:
 - a. Duplicate simple patterns (red, blue, red, blue).
 - b. Learn left to right orientation, and follow a linear sequence with set-up cues (use of assembly trays).
 - c. Use visual memory for placement of parts.
 - d. Duplicate a model (using color or shape cues).

Appropriateness of Activities

Activities should be short (initially 1 minute or less). The length of activities may increase to 5 minutes or perhaps longer; however, three 5-minute activities are more effective than one 15-minute activity. As programming continues and the child's tolerance increases, the number and duration of activities can be increased.

Initially, tasks should be designed to fit the child. The teacher should not try to fit the child to some preestablished work sample from a workshop. Good work tolerance behavior, interest in manipulating objects, cycle constancy, internalization of a routine, and underlying developmental skills should be developed first. The instructor should try to find tasks that are inherently interesting and stimulating to the child. All of the activities should have a clearly defined beginning and end.

Materials that are commonly associated with work activity should be used. Materials can be work-oriented and still have meaning for the child. Shiny wing nuts and bolts that spin are visually interesting, and the threads on the bolts are tactually interesting.

Retention of new learning and generalization of skills can be achieved more readily when clusters of activities are introduced rather than presenting one task repeatedly until a predetermined criterion can be met. The approach is to use a pool of task-analyzed, developmentally appropriate activities that require similar sensorimotor skills. The tasks are rotated. If two trials are completed on one task, and, for example, five other tasks requiring similar skills are introduced before the child repeats the first task, more accurate measurements of performance can be made. If there is improvement on the first task even though additional trials have not been performed, then it can be clearly demonstrated that some skills are being acquired.

Learning is possible through sensorimotor feedback brought about through the manipulation of objects and through the experience of using auditory, tactile, and visual senses. Teaching skills is

more useful than training specific activities when working with a child who is at the sensorimotor level.

Emphasis is not placed on work tolerance or production standards during the learning process. Rather, the task and the approach are modified to meet the learning needs of the child. When the task is mastered, then production becomes important.

Attention to tasks and interaction with objects in the environment are stressed. Once progress on the objectives has been made, the child should begin to show reduced self-stimulatory behavior. Reinforcement schedules or other specific attention to self-stimulatory behavior do not always need to be a part of the child's program. Emphasis should be placed on direction of effort and productive learning.

Documentation

In a learning situation data should be kept to find out if the task is appropriate for the child, not just to see how the child performs the task. The latter information is useful for evaluation, but in prevocational programs it is too often misused for teaching purposes.

The data should include (1) a description of the task; (2) number of trials and dates on which they occur; (3) instructional, physical, and gestural/verbal prompts for each trial; and (4) number of errors and time for each trial. Additional information on the types of skills required for the task help keep the learning process in perspective. This may include general hand function and prehension patterns required, prerequisite perceptual-motor abilities, and visual and tactile skills.

In writing individual educational plans, the teacher attempts to establish appropriate goals and objectives. Activities are graded according to developmental levels; however, prevocational programming has often excluded these considerations in the presentation of tasks. Developmental programming for children at the sensorimotor level may help some reach a preoperational stage; for others, it may help to refine and utilize the basic abilities they already have.

Current Services for the Deaf-Blind and Some Thoughts Toward Meeting Future Needs

Presented by Louis J. Bettica
Assistant Director,
Helen Keller National Center for Deaf-Blind Youths and Adults

In writing this paper, I have attempted to bring together impressions related to deaf-blindness based on my years of experience, and on my contacts with deaf-blind persons of all ages, professional workers at all levels of operation, and parents.

I deny having a crystal ball and, frankly, I have some question as to being a dreamer at this time. There is nothing wrong with dreaming at times, but I believe it is now time to face reality.

Thousands of pages of material have been written and millions of words have been spoken about deaf-blindness. Many of these statements have been made as a reflection of the worker's own subjective feelings, rather than a knowledgeable appraisal of objective findings. Many statements were made out of anxiety and frustration by persons with a sincere interest in deaf-blind individuals.

Several meetings at local and regional levels have been held to bring together parents and workers with varying degrees of success. Professional workers and parents must now join together to pool their knowledge, to make the best use of existing resources, and to seek methods of developing others.

While some individuals have been saying that nothing was happening, many things have happened. Since the inception of the Helen Keller National Center for Deaf-Blind Youths and Adults, much has been accomplished by those who work for the deaf-blind. Many of their achievements would not have been possible just a few years ago.

Since its inception in June, 1969, the Helen Keller National Center, which is operated by the Industrial Home for the Blind, has tried to develop services for deaf-blind persons throughout the country. Among its accomplishments are the following:

1. Information is disseminated through its Community Education Department, which is

directed by Robert J. Smithdas, a deaf-blind person. Dr. Smithdas, through his writings, articles in the *NAT-CENT NEWS*, his personal appearances at conferences, as well as radio and television appearances, has helped make the public more aware of the deaf-blind.

2. Manuals and professional articles are written by members of the Helen Keller National Center staff expressing their experiences in working with hundreds of deaf-blind individuals.
3. Seminars are held at the National Center's headquarters six or seven times a year. These provide professional workers with a week of intensive study of deaf-blindness, both academic and practical. Two- and three-day seminars on deaf-blindness also are held in various parts of the country to serve local, statewide, or regional groups.
4. Inservice training sessions for professionals are held at the headquarters facility. These sessions provide two or more weeks of more intensive study of deaf-blindness.
5. Regional representatives are in contact with agencies that serve deaf-blind persons throughout the 50 states. These representatives are helpful to these agencies in initiating or increasing services to the deaf-blind in their areas. Back in 1969, this writer, with the occasional help of a social worker, had to cover the entire country. Currently, there are eight regional representatives; and as soon as funding permits, this number will increase to ten, coinciding with the ten HEW regions. These representatives serve over 700 deaf-blind persons each year and over 1,000 deaf-blind persons during any two-year period. The agencies that they contact are serving many additional deaf-blind persons as a result of these contacts.

6. The National Center provides funding to other agencies, enabling them to serve deaf-blind men and women at the "grass roots" level. Currently, 13 staff members in 11 agencies are being funded by the National Center. They serve deaf-blind individuals within their local communities. This is "seed money" for a three-year period. The agency is encouraged to increase its services to the deaf-blind and to continue the program upon the termination of the three-year period. To date, there have been 12 agencies under this plan. Contractual arrangements are being made with two other agencies, and others will be added as funding permits. The National Center also has provided funds to train several specialists who work with the deaf-blind in their own states. These specialists can operate with a greater sense of freedom with the agencies serving blind, deaf, and other handicapped individuals.
7. The National Center's library contains an ever-increasing amount of material related to the subject of deaf-blindness. It is used by students and professional workers for research and study.

Efforts such as those described in the preceding paragraphs have led to an increased interest and involvement of professional workers and agencies. The regional representatives have been able to develop oases out of the vast desert that once stretched from coast to coast and border to border. Although these representatives have done a great deal, programs for the deaf-blind have shown renewed growth as a result of the Rehabilitation Act of 1973. This act states that the more severely handicapped shall be served; in fact, it specifically mentions the deaf-blind. The implication of the 1973 act is now being felt. It is not only breaking down some of the last barriers of resistance, but has brought about some rather aggressive efforts on the part of some agencies. Increased interest and involvement are bringing about a better understanding of the needs of the deaf-blind adult and, perhaps equally important, the identification of deaf-blind individuals throughout the country.

I want to give you an example of the difference in attitude and knowledge about this population. In 1970 I visited two agencies and met with the executive directors to ask for their opinions of the number of deaf-blind people in their states. One of them stated six, and the other stated three. The director who stated three did this at a meeting with members of his staff, and upon close questioning

of the other staff members, we learned that they could identify 46, but nowhere was there an administrative awareness of this number. In regard to the executive director who stated six, if you were to ask him today for the number, he would tell you that the number is now in three figures.

Increased awareness has brought about a need for greater and more extensive services for this group. One can easily see that the number of deaf-blind adults is far greater than what we were led to expect in 1967, at the time of the Rehabilitation Act which established the National Center for Deaf-Blind Youths and Adults. This awareness has compelled the 50 states to reconsider their efforts and increase their services.

I do not believe that deaf-blindness among the adult population has increased within the past 20 years. This increased number simply means that the greatest percentage of this group was unknown and, therefore, had received no services other than that of a custodial nature, both at home and in institutions. A national register of the deaf-blind is being developed. It will identify the deaf-blind and categorize them into various age groups.

Since we are seeing increased service systems developed as a result of the efforts made by the Helen Keller National Center staff, the passage of the Rehabilitation Act of 1973, and the increased awareness of the number of deaf-blind persons needing services, strategies related to the population of children should be developed to identify and more accurately classify those children who are now listed as "deaf-blind." To continue to simply identify all as "deaf-blind" as they approach adulthood may bring about much confusion.

I have long favored the classification of this population for the purpose of clarification. In 1976 in Chicago, I made the following statement (Reference 1):

Although much time can be spent on identification, the classification of the deaf-blind individual becomes of paramount importance for individualized planning. It is true that we often talk in terms of numbers when talking about the group, and this is important. However, planning cannot really take place until we know for whom we are making plans. It is not enough to say that there are approximately 10,000 deaf-blind boys, girls, men, and women, since this tells us nothing about their ages and their specific handicaps. With regard to the ages of this population, it is important to know how many men and women are within the employable age group. We also are interested in knowing the number of children currently in educational programs with emphasis on those who are reaching twenty-one years of age.

In classifying this population, efforts should be made to learn the extent of both hearing and visual loss or, to put it on a positive note, to learn how much hearing and vision the individual has. Uppermost in our minds is the number of children affected by the rubella epidemic of 1964-65. Of course, there is serious concern about the need for some constructive planning for these individuals as they reach adulthood. To do this properly, we need to accurately identify and classify the children. Now we are at a time when we must know precisely how many children we are talking about.

The term "deaf-blind" for children has been a catch-all category. There was no objection to this, since it enabled many with questionable sensory disabilities to have the opportunity to receive an educational program which otherwise would have been denied to them. It is also true that many of the children functioned as deaf-blind when they were infants. The category of deaf-blind served its purpose well, but as we think and plan for the future, separation into more specific classification becomes increasingly important. The definition used by the children's program is broad and permits a wide range of visually and hearing-handicapped children to fall within its framework. The children's program is also aware of this since many of the children are, according to program administrators, "visually and hearing impaired."

Recently, I was asked to meet six youngsters (between the ages of eighteen and twenty) who were referred to me as deaf-blind. Upon meeting them, I quickly noticed that all had quite good vision, but more important, five of the six could hear me speaking with no difficulty at all. Although each wore a hearing aid, their ability to understand speech so well makes it unnecessary for them to receive training at a facility such as the Helen Keller National Center. Instead, referral should be made to an agency serving the blind. I might further add that hearing-impaired youngsters or adults should not be placed with deaf people, but with others who have hearing and speech, thus enabling them to utilize their own hearing to better advantage.

Therefore, when thinking about planning, it is recommended that we start talking about handicaps in more specific terms. My suggestions are as follows:

Deaf-blind. Those whose visual loss is within the classification of blind as stated in the tax form. Deafness is the inability to understand connected speech or the need to use a means of communication other than through the ear.

Visually impaired. Those whose vision is better than that described above.

Hearing impaired. Those whose hearing is good enough to enable them to communicate by voice.

The preceding definition for "deaf-blind" is the one used as part of the criteria for entrance into the training program at the Helen Keller National Center (Reference 2).

The three classifications described above should help identify the type of agency that has the responsibility for administering services to the handicapped. Services to the handicapped are fairly consistent throughout the country, although variations exist from state to state as to the types of handicaps served and minimum ages for application or registration. Someone from each state should learn this information and transmit it to each parent for action. Although nothing may appear to happen, each agency must become aware of the forthcoming population if meaningful plans are to be made. It is also important to proceed along these lines at the earliest appropriate time since many other multihandicapped children were stricken during the same epidemic, and competition for funding will be intense.

Until now only the sensory losses have been identified as a prelude to possible referral. Other characteristics must be identified. Many deaf-blind children have central nervous system defects, along with other physical handicaps, in addition to the sensory losses. This has compounded the problems of educators, families, and the children themselves. It, therefore, becomes important to identify each child's physical handicap and level of functioning, in order to avoid the concept that these children are only deaf-blind since, in reality, many are deaf-blind multihandicapped. Observations of these individuals clearly indicate that they function on several levels, and apparently this will continue into the foreseeable future. All of you are aware that millions of dollars have been spent on the education of this group. Hundreds of workers, both in school and out, and thousands of parents have diligently applied themselves toward the children, but, and I quote Lars Guldager, the Superintendent of Oak Hill School in Connecticut (Reference 3):

Despite this effort, many students graduating after as many as 18 to 20 years in such a program will be unable to take care of their own needs. The majority of the students leaving programs for deaf-blind children at the age of twenty-one will be in need of a life-long program to meet their need.

Although the need for life-long planning for the deaf-blind is obvious, the questions "What?" "When?" "How?" "For whom?" and "How much?" must be answered before funding can be obtained for appropriate and constructive services.

Despite the fact that many communities offer resistance, the concept of the group home versus institutionalization continues to grow. This writer

and the Helen Keller National Center truly believe that custodial care, as it has been known in the past, no longer has a place in this society, and every deaf-blind person, no matter how limited or advanced, should have the opportunity to an environment that promotes growth.

Some thoughts should be given toward the concept of "dependent living homes" for the very low functioning person, as Dr. Guldager states in his paper, or "rehabilitation maintenance," as Harry Spar, the Director of the Helen Keller National Center, states in his paper, "What the Future May Hold for the Deaf-Blind Child." In that 1972 paper (Reference 4), Mr. Spar says:

A special kind of residential work activity center with provision for ongoing rehabilitation maintenance may be required to best serve these deaf-blind persons.

Group homes can offer help at various levels from dependent living up to semi-independent living, with opportunities provided for some type of purposeful activity in or out of the home.

Some group homes that serve the multihandicapped can be considered a suitable placement for a number of the children. Other living areas may have to be developed specifically for deaf-blind persons who will need appropriate staff to ensure the safety and continued growth of each individual.

The services must continue when deaf-blind children move from childhood to adulthood. A successful legislative program on the city, state, or national level can be achieved only when several interested and compassionate legislators are willing to present a bill for funding and when professional workers and parents work together to present the legislators with meaningful information.

Assuming that age twenty-one is the cutoff point for school, although efforts should be made at easing this level for some individuals, it becomes more apparent that the educators will face an increasingly anxious period in helping to focus upon ultimate placement.

It appears to this writer that many teachers have been preoccupied with the concept that they have to train the child to work on a specific work task. One often hears the question "What will the deaf-blind child do?" In actuality, successful placement of any type can be achieved only when it is known what the deaf-blind child can do.

No doubt some will ultimately go on into independent or semi-independent living without the need for very close supervision. They will achieve this because they show the potential, and

post-school training will help to sharpen their skills and overcome their weaknesses.

Placement, whether in competitive employment, independent living, or dependent living, can only be determined upon an objective evaluation and observation of the total person. The fact that one person has the dexterity to work on complex assemblies does not of itself make him or her suitable for competitive placement. In a paper I wrote with Robert Prause, the placement specialist at the Helen Keller National Center, we stated (Reference 5):

There are more jobs lost because of poor work habits and attitudes than because of poor production performance.

The article also implied that, rather than focus on a job task, the teacher should concentrate on developing the individual's readiness for work.

Developing certain necessary work skills for placement does not have to be limited to work tasks. Such skills can be achieved through crafts, recreation, social game programs, and any type of creative activity. These can be helpful in developing the attention span, increasing the frustration tolerance, improving manual coordination and, perhaps as important as anything else, developing acceptable social skills.

One must not overlook the need to increase the expectations of each child, both at school and at home, regardless of the child's limitations. Not to do this will only lead to regression.

In reality, teachers and parents should not think in terms of developing a specific job task for each child. They should work toward helping the child to function as an adult.

Children should be registered at the earliest appropriate time with the appropriate state agency. Currently, there are many more private agencies serving the deaf-blind multihandicapped adults than ever before, and an increasing number of these show evidence of accepting the challenge. Many workers in all fields now have some familiarity with deafness and with the methods of communication and manual language. Most important of all, they have an interest in becoming involved.

Energetic efforts should be made to develop a financial structure for the development of group homes, or any other types of appropriate facilities or programs, to ensure the continuation of those services that many will need.

The skills of deaf-blind children should be maximized to provide the type of community

experience that will better prepare them for the lifestyle, away from a school setting, that they will experience several years from now. Children will respond best to the communication method that is easiest for them to learn. On any level it is important to continue communicating, with special emphasis on expressive language.

As I said initially, dreaming time is over, and reality time is upon us. Let us not sit and ask: "What shall we do?" Let us work together and decide; let us offer suggestions. Many suggestions

may be rejected, but out of rejection comes alternatives, and out of alternatives shall come success.

Undoubtedly, some parents will not be entirely satisfied, and some workers will not be entirely satisfied. However, in the final analysis, it is the handicapped children who should be satisfied. The handicapped children deserve the best knowledge and skill we have to offer to maximize their abilities, and they must be treated with respect and dignity to maximize their feelings of self-worth.

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Developing Resources for Deaf-Blind Youths and Adults

Presented by Dean Wyrick, Field Services Coordinator,
Helen Keller National Center for Deaf-Blind Youths and Adults

The Bureau of Education for the Handicap's ten regional centers for deaf-blind children, interested parents, and professional workers have contributed significantly to establishing a national awareness of the 1963-65 rubella epidemic's high incidence of deaf-blind children with severe multi-handicapping disabilities. Many sincere individuals have worked to establish programs and facilities to meet the multifaceted needs of the deaf-blind when they are no longer eligible for participation in the educational programs. However, it is unfortunate that this awareness has not initiated the adequate development of the appropriate programs, training resources, and residential facilities that are going to be required.

The Helen Keller National Center's field services department began in 1969 with only two staff persons to serve the entire United States. Then regional offices were opened, with one representative and a secretary at each office, first in Glendale, California, in 1970, and later in Atlanta, Chicago, Philadelphia, Dallas, Seattle, and Denver. Finally, the eighth representative began working out of the main facility in Sands Point, New York. These representatives have worked closely with state vocational rehabilitation agencies and other interested public and private agencies, offering them encouragement with consultative and technical assistance. They have helped initiate specialized rehabilitation programs for deaf-blind youths and adults on a state-by-state basis. However, the Helen Keller National Center soon recognized that, although the encouragement and consultative assistance offered by its regional representatives helped to promote the initiation of a few specialized rehabilitation programs for deaf-blind youths and adults in agencies conducting sound rehabilitation programs, many agencies were hesitant about extending the full complement of their services to the deaf-blind.

Consequently, in 1974 the Helen Keller National Center initiated an affiliation program to develop specialized programs of services for deaf-blind

youths and adults within a national network of agencies. This program offers to a selected number of approved agencies reimbursement of the direct costs, for up to three years, required for a full-time staff specialist in services for the deaf-blind and, in special circumstances, an assistant staff specialist. During the initial three-year affiliation period, the staff specialist, with special training at the Helen Keller National Center and with assistance from the regional representatives serving the state in which the affiliated agency is located, helps develop his or her agency's capacity to serve deaf-blind youths and adults. Each agency understands that the specialized program will be continued, if proven successful, at its own expense when funding from the Helen Keller National Center is terminated.

For the 12-month period ended March 31, 1978, affiliated agencies of the Helen Keller National Center served 375 deaf-blind youths and adults (98 in their own facilities and 277 in the field). A total of 58 deaf-blind persons have completed specialized training offered by these affiliated agencies.

Unfortunately, the development of such training resources does not guarantee that all deaf-blind youths are being effectively moved from educational programs into the rehabilitation services delivery system. The transition of each deaf-blind youth from education to rehabilitation can be a smooth one if the transition is planned for each student on an individual basis. Those who plan the transition include the student's teachers and other staff workers responsible for his or her educational development, the appropriate vocational rehabilitation counselor, the Helen Keller National Center's regional representative serving the state in which the student resides, other rehabilitation professionals who have special knowledge about the student or about deaf-blindness, and, of course, the student and his or her parents.

Because the Helen Keller National Center occasionally does not learn about some deaf-blind youths until they reach the age of twenty-one or

twenty-two years of age, I believe there is a possibility that some staff workers in some educational programs may not be fully aware of the importance of referring deaf-blind individuals to the appropriate state vocational rehabilitation agency at a much earlier age. In most states an application for vocational rehabilitation can be made at about the age of fourteen to sixteen years. Referral of deaf-blind youths to state vocational rehabilitation agencies at the earliest age at which applications for such services are usually accepted is extremely important so that cooperative planning may be initiated and offered for deaf-blind youths and adults as early as possible and should never be delayed until a youth reaches twenty-one or twenty-two years of age. Also, it is important because sponsorship usually is required by the appropriate state vocational rehabilitation agency in order for a deaf-blind person to enroll for training at the Helen Keller National Center, to participate in any of the affiliated agencies, or to receive services from most other rehabilitation training programs.

Every concerned individual can help by making certain that referrals are made and that applications for vocational rehabilitation services are, in fact, made by all deaf-blind youths. Additionally, the regional representative should be alerted when

a deaf-blind youth makes an application for vocational rehabilitation services. The regional representative may then advise the vocational rehabilitation counselor involved that the Helen Keller National Center is available to help plan individual programs for deaf-blind persons.

In some states a single vocational rehabilitation agency is responsible for providing rehabilitation services to all handicapped persons, regardless of the nature of their disabilities. Some states have a separate vocational rehabilitation agency to serve blind persons and a different rehabilitation agency to serve individuals with all other disabilities, including deafness. In states that have separate vocational rehabilitation agencies responsible for serving the blind and the deaf, some have established policies or written agreements whereby provisions are made to designate which agency is responsible to serve deaf-blind persons and under what circumstances; however, in some states, such agreements have not been established.

When it is unclear as to which vocational rehabilitation agency a referral should be made, one should contact the regional representative of the Helen Keller National Center serving the state in which the deaf-blind individual resides. The representative can help determine the appropriate agency in each case.

Appendix

Conference Participants

NEW ENGLAND REGIONAL CENTER FOR SERVICES TO DEAF-BLIND CHILDREN

John B. Sinclair, Coordinator
New England Regional Center for Services to
Deaf-Blind Children
Perkins School for the Blind
175 North Beacon Street
Watertown, MA 02172

Rosemarie Burton
Project Director
Southbury Training School
Southbury, CT 06488

Martha Delaney
Oak Hill School
120 Holcomb Street
Hartford, CT 06112

David P. Dorr, Supervisor
Special Education
Visually Handicapped
Division of Eye Care
32 Winthrop Street
Augusta, ME 04330

Trudy Kaehler
Educational Consultant
New England Regional Center for Services to
Deaf-Blind Children
Perkins School for the Blind
175 North Beacon Street
Watertown, MA 02172

Martha Majors
Perkins School for the Blind (Sponsoring Agency)
175 North Beacon Street
Watertown, MA 02172

Betsy McGinnity, Teacher
Hogan Regional Center
P.O. Box A
Hathorne, MA 01937

W. Michael Minihane
Vocational and Educational Specialist
New England Regional Center for Services to
Deaf-Blind Children
Perkins School for the Blind
175 North Beacon Street
Watertown, MA 02172

Carolyn Pellegrino
8 Hancock Road
Barrington, RI 02806

Elaine Pronovost
100 Marsh Drive
Fairfield, CT 06430

Allen B. Sanderson
Administrative Consultant
New England Regional Center for Services to
Deaf-Blind Children
Perkins School for the Blind
175 North Beacon Street
Watertown, MA 02172

Charles C. Woodcock, Director
(New England Regional Center for Services to
Deaf-Blind Children Project Director)
Perkins School for the Blind (Sponsoring Agency)
175 North Beacon Street
Watertown, MA 02172

Ruth Zimmerman, Program Director
Massachusetts Association for the Blind
200 Ivy Street
Brookline, MA 02146

**MID-ATLANTIC NORTH CARIBBEAN REGIONAL CENTER
FOR SERVICES TO DEAF-BLIND CHILDREN**

Khogendra N. Das, Coordinator
Mid-Atlantic North Caribbean Regional Center for
Services to Deaf-Blind Children
c/o New York Institute for the Education of the
Blind
999 Pelham Parkway
Bronx, NY 10469

Thomas Brown
State Coordinator for Deaf-Blind
New Jersey Department of Education
225 West State Street
Trenton, NJ 08525

Richard Connell
Supervisor of Exceptional Program
Delaware State Department of Public Instruction
The Townsend Building
Dover, DE 19901

Shui Sin Das
Supervisor/Teacher Experimental Class
New York Institute for the Education of the Blind
999 Pelham Parkway
Bronx, NY 10469

David George
Prevocational/Vocational Specialist
Mid-Atlantic North Caribbean Regional Center for
Services to Deaf-Blind Children
c/o New York Institute for the Education of the
Blind
999 Pelham Parkway
Bronx, NY 10469

Wilma Jeff
Social and Child Care Services Specialist
Mid-Atlantic North Caribbean Regional Center for
Services to Deaf-Blind Children
c/o New York Institute for the Education of the
Blind
999 Pelham Parkway
Bronx, NY 10469

Susanna Lee
Coordinator of Deaf-Blind Services
Margaret S. Sterck School for the Hearing Impaired
Chestnut Hill Road and Cherokee Drive
Newark, DE 19713

Rita Nadler, Teacher
889 Edwards Road, Apt. A-8
Parsippany, NJ 07054

Mary O'Donnell
2 Whitney Terrace
Verona, NJ 07044

William O'Donnell
2 Whitney Terrace
Verona, NJ 07044

Francine Serrao
Supervisor of Deaf-Blind Program
New Jersey Commission for the Blind
1100 Raymond Boulevard
Newark, NJ 07102

Jeff Sheldon
Educational Specialist
Mid-Atlantic North Caribbean Regional Center for
Services to Deaf-Blind Children
c/o New York Institute for the Education of the
Blind
999 Pelham Parkway
Bronx, NY 10469

Roger C. Walker
Project Director
New York Institute for the Education of the Blind
999 Pelham Parkway
Bronx, NY 10469

Jeannetta Walsh
Educational Diagnostician
Mid-Atlantic North Caribbean Regional Center for
Services to Deaf-Blind Children
c/o New York Institute for the Education of the
Blind
999 Pelham Parkway
Bronx, NY 10469

**SOUTH ATLANTIC REGIONAL CENTER
FOR SERVICES TO DEAF-BLIND CHILDREN**

A. Jeff Garrett, Coordinator
South Atlantic Regional Center for Services to
Deaf-Blind Children

Division for Exceptional Children
Department of Public Instruction
Education Building
Raleigh, NC 27611

Angela Blatchley, Teacher
Great Oaks Center
12001 Cherry Hill Road
Silver Spring, MD 20904

Norman Camp
Deputy Assistant Director
Office of the Assistant Secretary for Children
Department of Human Resources
Room 512
Albermarle Building
Raleigh, NC 27611

Marvin Efron, Optometrist
Educational Consultant
P.O. Box 45
1212 Canary Drive
West Columbia, SC 29169

Jan Feserman
Helen Keller Affiliate
Counselor for the Deaf-Blind
Rehabilitation Center for the Blind
P.O. Box 33
Butner, NC 27509

Fayette Geraty
North Carolina Consultant for Services to Deaf-
Blind Children
Division for Exceptional Children
Department of Public Instruction
Education Building
Raleigh, NC 27611

Belinda Hill, Teacher
Deaf-Blind Program
West Virginia Schools for the Deaf and Blind
Romney, WV 26757

Robert Holzberg, Administrator
Schools for the Deaf and Blind
Cedar Spring Station
Spartanburg, SC 29302

Larry Hutto, Audiologist
Chesapeake Hearing and Speech Association
700 Melvin Avenue
Annapolis, MD 21401

Francis Locks
Supervisor, Deaf-Blind Program
District of Columbia Children's Center
(Forest Haven)
Laurel, MD 20810

Vera Maizels
Consultant for Services to Deaf-Blind Children in
the District of Columbia
Reno Administrative Annex
4820 Howard Street, N.W.
Washington, DC 20016

Reba Rash, Teacher
Center for Human Development
3500 Ellington Street
Charlotte, NC 28211

Patricia Rogers
Route 2, Wintergreen Lane
Taylor, SC 29687

William Rogers
Route 2, Wintergreen Lane
Taylor, SC 29687

Jane Tanana
Assistant Coordinator/Educational Consultant
South Atlantic Regional Center for Services to
Deaf-Blind Children
Division for Exceptional Children
Department of Public Instruction
Education Building
Raleigh, NC 27611

SOUTHEAST REGIONAL CENTER FOR DEAF-BLIND CHILDREN

John W. Crosby, Coordinator
Southeast Regional Center for Deaf-Blind Children
P.O. Box 698
Talladega, AL 35160

John Askew
Director of Deaf-Blind Program
Ellisville State School
Ellisville, MS 39437

Laura P. Carr
Teacher/Evaluator
Multisensory Handicapped Program
Arlington Developmental Center
P.O. Box 399
Arlington, TN 38002

Beverly Cousins, Consultant
Health and Rehabilitation Services
1311 Winewood Boulevard
Tallahassee, FL 32301

Jane Frederick
630 Abberley Way, Apt. 3
Stone Mountain, GA 30083

Georgia Granberry
Ellisville State School
Ellisville, MS 39437

Thylia Henderson
987 E. Northside Drive
Apt. 10-2A
Jackson, MS 39206

Joel R. Hoff, Coordinator
Services for Deaf-Blind Children
Florida School for the Deaf and Blind
P.O. Box 1209
St. Augustine, FL 32084

York Hudgins, Assistant Director
Special Education Programs
DeKalb County School System
385 Glendale Road
Scottdale, GA 30079

Linda Kates, Coordinator
Programs for the Deaf-Blind
Kentucky School for the Blind
P.O. Box 6005
Louisville, KY 40206

Susan Kershman
Department of Special Education
University of Kentucky
224 Taylor Education Building
Lexington, KY 40506

Deborah Napier
Cardinal Hill Hospital
2050 Versailles Road
Lexington, KY 40504

Deborah Strawn
Outreach Teacher
Auburn University Deaf-Blind Project
1156 Haley Center
Auburn, AL 36830

Sara R. Walsh
Program Specialist
Southeast Regional Center for Deaf-Blind Children
P.O. Box 698
Talladega, AL 35160

**MIDWEST REGIONAL CENTER FOR SERVICES
TO DEAF-BLIND CHILDREN**

George Monk, Coordinator
Midwest Regional Center for Services to Deaf-Blind
Children

P.O. Box 420
Lansing, MI 48902

Barbara J. Bjorling
Education Consultant
Midwest Regional Center for Services to Deaf-Blind
Children

P.O. Box 30008
Lansing, MI 48909

Margaret Burley
3505 La Rue Prospect Road, South
Prospect, OH 43342

Joan Burton, Director
Stone Belt Center
2815 E. 10th Street
Bloomington, IN 47401

Urbano Censoni, Supervisor
Michigan Department of Mental Health
Lewis Cass Building
Lansing, MI 48926

Marsha Fritz
Lincoln School
608 Algoma Boulevard
Oshkosh, WI 54901

Jerri Hoffman
Columbus State Institute
Ohio Department of Mental Health and Mental
Retardation

1601 W. Broad Street
Columbus, OH 43223

Theodore Lockett
Midwest Regional Center for Services to Deaf-Blind
Children

P.O. Box 420
Lansing, MI 48902

Jerry Lovrien
Deaf-Blind Department
Brainerd State School
Brainerd, MN 56401

Sue Miller
Traverse Bay Area School District
2325 N. Garfield
Traverse City, MI 49684

Al Sanders
6336 Beechwood
Mattison, IL 60443

SOUTH CENTRAL REGIONAL CENTER FOR SERVICES TO DEAF-BLIND CHILDREN

Jack English, Coordinator
South Central Regional Center for Services to
Deaf-Blind Children
University of Texas at Dallas
Callier Campus
1966 Inwood Road
Dallas, TX 75235

Charles Freeman
Bureau for the Blind
Missouri Division of Family Services
619 East Capitol Avenue
Jefferson City, MO 65101

Sherry Furlow
300 Sherrouse Avenue
East Monroe, LA 71201

Ed Hammer
South Central Regional Center for Services to
Deaf-Blind Children
University of Texas at Dallas
Callier Campus
1966 Inwood Road
Dallas, TX 75235

Anna Hennessey
Pleasant Hill, MO 64080

Barbara Huban
805 West 29th Street
North Little Rock, AR 72201

Jane Johnston
11101 Independence Avenue
Independence, MO 64051

Jan Kostoryz
610 East 22nd Street
Kansas City, MO 64188

Carol Kruse
Iowa Braille and Sight Saving School
Vinton, IA 52349

Fred Mettlach
241 North Street
Baton Rouge, LA 70802

Jenelda Smith
Route 3
Hammon, OK 73650

Woody Sterling
South Central Regional Center for Services to
Deaf-Blind Children
University of Texas at Dallas
1966 Inwood Road
Dallas, TX 75235

Carolyn Torrie
South Central Regional Center for Services to
Deaf-Blind Children
University of Texas at Dallas
1966 Inwood Road
Dallas, TX 75235

Anne Wallace
Department of Education
Special Education
State Capitol Grounds
Little Rock, AR 72201

Jim West
South Central Regional Center for Services to
Deaf-Blind Children
University of Texas at Dallas
Callier Campus
1966 Inwood Road
Dallas, TX 75235

Muriel Yu
Oliver Hodge Memorial Building
Government Complex
Room 263
Oklahoma City, OK 73105

MOUNTAIN PLAINS REGIONAL CENTER FOR SERVICES TO DEAF-BLIND CHILDREN

John Ogden, Coordinator
Mountain Plains Regional Center for Services to
Deaf-Blind Children
165 Cook Street, Suite 304
Denver, CO 80206

Teri Allen
Educational Program Specialist
Mountain Plains Regional Center for Services to
Deaf-Blind Children
165 Cook Street, Suite 304
Denver, CO 80206

Pam Cerday
1426 Tenth Avenue, No. 10
Grand Forks, ND 58201

Douglas Clark
State Liaison Person
Special Education Section
State Department of Education
301 Centennial Mall, South
Lincoln, NE 68509

Mark Fraser
Parent and Family Services Specialist
Mountain Plains Regional Center for Services to
Deaf-Blind Children
165 Cook Street, Suite 304
Denver, CO 80206

Kathy Gunter
506 S. 12th
Laramie, WY 82070

Jim Hilber
Counselor, Services for the Deaf
Utah State Board of Education
Services to the Deaf
250 East 5th South
Salt Lake, UT 84111

Margie Kahat
Supervising Teacher
State Home and Training School
10285 Ridge Road
Wheatridge, CO 80033

Phyllis Kelly
State Liaison for Kansas
Special Education Administration Section
Kansas Department of Education
120 E. 10th Street
Topeka, KS 66612

Jim Parry
Special Education
State Office Building 3
Pierre, SD 57501

Ann Stoddard
Prevocational/Vocational Specialist
Mountain Plains Regional Center for Services to
Deaf-Blind Children
165 Cook Street, Suite 304
Denver, CO 80306

Linda Westover
Teacher
Colorado School for the Deaf and Blind
Kiowa and Institute Streets
Colorado Springs, CO 80903

NORTHWEST REGIONAL CENTER FOR DEAF-BLIND CHILDREN

Ken Patten, Coordinator
Northwest Regional Center for Services to Deaf-
Blind Children
3411 South Alaska Street
Seattle, WA 98118

Linda Begbie
Northwest Regional Center for Services to Deaf-
Blind Children
3411 South Alaska Street
Seattle, WA 98118

Barbara Haas
Fircrest School
Seattle, WA 98101

Lee Hagmeier
Northwest Regional Center for Services to Deaf-
Blind Children
3411 South Alaska Street
Seattle, WA 98118

Bob Huven
Montana State School for the Deaf and Blind
Great Falls, MT 59401

Dan Ludewick
Northwest Regional Center for Services to Deaf-
Blind Children
3411 South Alaska Street
Seattle, WA 98118

Olive McCarty
Montana State School for the Deaf and Blind
Great Falls, MT 59401

Ruby Noji
Child Development and Retardation Center
Portland, OR 97201

LeAnne Petroch
Idaho State School for the Deaf and Blind
Gooding, ID 83330

Phyllis Pyle
36720 5th Avenue, South
Auburn, WA 98002

Paulette Vafakos
Fairview Hospital and Training Center
Salem, OR 97301

SOUTHWESTERN REGION DEAF-BLIND CENTER

William A. Blea, Director
Southwestern Region Deaf-Blind Center
721 Capitol Mall
Sacramento, CA 95814

Marjory Becker
1918 Pinto Lane
Las Vegas, NV 89106

Valerie Bland
6107 Barclay Street
San Jose, CA 95123

Deborah Bremer
P.O. Box 472
Forest Knolls, CA 94933

Jackie Daniels
Sultan Easter Seal School
710 Green Street
Honolulu, HI 96813

Margo Dronek
Curriculum Specialist
Southwestern Region Deaf-Blind Center
721 Capitol Mall
Sacramento, CA 95814

John I. Flores
Assistant Superintendent of Public Instruction; and
Assistant Director, Office of Special Education
Department of Education
721 Capitol Mall
Sacramento, CA 95814

Victoria Harper, Director
Special Education
Department of Education
P.O. Box DE
Agana, GU 96910

Richard L. Johnston
Media Specialist
Southwestern Region Deaf-Blind Center
721 Capitol Mall
Sacramento, CA 95814

Miles Kawatachi, Director
Special Needs Branch
State of Hawaii
Department of Education
P.O. Box 2360
Honolulu, HI 96804

Edgar Lowell, Director
John Tracy Clinic
806 West Adams Boulevard
Los Angeles, CA 90007

Clinton A. Paulson
Family and Community Service Specialist
Southwestern Region Deaf-Blind Center
721 Capitol Mall
Sacramento, CA 95814

Camelia Robles
15050 Pintura Drive
Hacienda Heights, CA 91745

Rodger Russell
Prevocational/Vocational Consultant
Southwestern Region Deaf-Blind Center
721 Capitol Mall
Sacramento, CA 95814

Allan Schlemmer
509 University Avenue, No. 401
Honolulu, HI 96814

Conchita Schlemmer
509 University Avenue, No. 401
Honolulu, HI 96814

Paul Starkovich, Program Consultant
Southwestern Region Deaf-Blind Center
721 Capitol Mall
Sacramento, CA 95814

Mary Tarling, Teacher
Deaf-Blind Class
Pace School
9625 Van Ruiten Street
Bellflower, CA 90706

Billy R. Wales
Special Education Assistant I
Southwestern Region Deaf-Blind Center
721 Capitol Mall
Sacramento, CA 95814

Paul Yee, Jr.
Governmental Program Analyst
Southwestern Region Deaf-Blind Center
721 Capitol Mall
Sacramento, CA 95814

TEXAS EDUCATION AGENCY

Kenneth Crow, Coordinator
Special Education Program for the Deaf-Blind
201 East 11th Street
Austin, TX 78701

Judy Burton, Teacher
University of Texas at Dallas
Callier Center for Communication Disorders
Deaf-Blind Classrooms
1966 Inwood Road
Dallas, TX 75235

Patricia English
Prevocation Consultant
University of Texas at Dallas
Callier Center for Communication Disorders
Deaf-Blind Program
1966 Inwood Road
Dallas, TX 75235

Charles Raeke
State Supervisor of Program Evaluation
Texas Commission for the Blind
314 West 11th Street
Austin, TX 78711

Dale Rudin
Deaf-Blind Supervising Teacher
Educational Programming
Capital Area Rehabilitation Center
919 West 28½ Street
Austin, TX 78705

Ann Silverain, Teacher
Texas School for the Blind
Deaf-Blind Annex
3710 Cedar
Austin, TX 78705

Ann Smisko
Chief Consultant
Special Education
Program for the Deaf-Blind
201 East 11th Street
Austin, TX 78701

Gretchen Stone
Prevocation Coordinator
Texas School for the Blind
Deaf-Blind Annex
3710 Cedar
Austin, TX 78705

Tom Valentine
Consultant
Special Education
Program for the Deaf-Blind
201 East 11th Street
Austin, TX 78701

Annie Wade, Parent
1211 Ruth
Austin, TX 78757

Garland Wade, Parent
1211 Ruth
Austin, TX 78757

GUESTS

Steve Barrett
South Central Region Representative
1111 W. Mockingbird Lane
Suite 1540
Dallas, TX 75247

Hank Baud
1515 Columbia College Drive
Columbia, SC 29203

Louis Bettica ACSW
Assistant Director
Headquarters
111 Middle Neck Road
Sands Point, NY 11050

Dan Burns
Lynchburg Training School/Hospital
Child Development Center
P.O. Box 1098
Lynchburg, VA 24505

Gary Cardiff
President, The National Association
for the Deaf-Blind
1109 Memorial Highway No. 16
Bismarck, ND 58501

Jackie Coker
7692 Rotherton Way
Sacramento, CA 95823

Robert Dantona, Coordinator
Centers and Services for Deaf-Blind Children
Bureau of Education for the Handicapped
400 6th Street, S.W.
(Donohoe Building, Room 4046)
Washington, DC 20202

Pamela Dortch
Siegel Institute
3033 South Cottage Grove
Chicago, IL 60616

Betty Dowdy
4118 Adams
Kansas City, KS 66103

Leonard Dowdy
4118 Adams
Kansas City, KS 66103

Barbara Franklin
Department of Special Education
San Francisco State University
San Francisco, CA 94132

Jatis Franklin
Program Officer
Centers and Services for Deaf-Blind Children
Bureau of Education for the Handicapped
400 6th Street, S.W.
(Donohoe Building, Room 4046)
Washington, DC 20202

Constance Gant, Director
Communication Impairment
Bureau of Rehabilitation Services
Room 305
122 "C" Street, N.W.
Washington, DC 20001

Candy Haight
Siegel Institute
3033 South Cottage Grove
Chicago, IL 60616

Wanda Hicks
Program for Hearing Impaired/Vision Impaired
Gallaudet College
Florida Avenue and 7th Street, N.E.
Washington, DC 20002

Merryl Kaye
c/o Perkins School for the Blind
175 N. Beacon Street
Watertown, MA 02172

Richard Kinney
Hadley School for the Blind
700 Elm Street
Winnetka, IL 90093

Daryl Konrad
Project Supervisor
Prevocational Training Program
Seattle Lighthouse for the Blind
P.O. Box C-14119
Seattle, WA 98114

Clifford Lawrence
16 Clarke Road
Andover, MA 01810

Roderick Macdonald
800 4th Street, S.W.
Apt. 707 South
Washington, DC 20024

Susan McKeehan, Director
Rainier School for Retarded
P.O. Box 600
Buckley, WA 98321

Joe Parnicky
Ohio State University
Nisonger Clinic
1580 Cannon Drive
Columbus, OH 43210

Jack Quinn
55 Washington Place 3
Newtonville, MA 02160

Fern Russell
3941 Calimyrna Road
Acampo, CA 95220

Jerome Schein
New York University
Deafness Research and Training Center
80 Washington Square East
New York, NY 10003

Vera Schiller
Southwestern Region Representative
102 North Brand Boulevard
Glendale, CA 91203

Patricia Simmons
Department of Special Education
California State University
Los Angeles, CA 90032

Bernita Sims-Tucker
Coppin State College
Baltimore, MD 21216

LeRoy Spaniol
52 Allerton Street
Brookline, MA 02146

David Tweedie
Gallaudet College
Florida Avenue and 7th Street, N.E.
Washington, DC 20002

Edward J. Waterhouse
20 Park Lane
East Walpole, MA 02032

Everett Wilcox, Superintendent
California School for the Blind
3001 Derby Street
Berkeley, CA 94705

Enid Wolf
Supervising Director
Program Planning and Development
RFD-3
P.O. Box 327
Annapolis, MD 21403

Craig Wright
Northwestern Region Representative
649 Strander Boulevard
Suite C
Seattle, WA 98188

Dean Wyrick, C.R.C.
Field Services Coordinator
1111 W. Mockingbird Lane
Suite 1540
Dallas, TX 75247

Sandra Young
c/o Robert R. Moten, Inc.
2001 S. Street, N.W.
Suite 601
Washington, DC 20009